

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036632

Facility Name: COUNTRYSIDE HEALTHCARE CENTER

Address: 1635 EAST 154TH ST. DOLTON 60419
Number City Zip Code

County: COOK

Telephone Number: (847) 329-1555 Fax # (847) 329-9555

IDPA ID Number: 36-3730831

Date of Initial License for Current Owners: 11/01/90

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	SHERWIN I. RAY	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585	Fax # (847) 675-5777
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

0036632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>100</u>	<u>36,600</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,502</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>197</u>	TOTALS	<u>197</u>	<u>72,102</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,408</u>	<u>2,408</u>	8
9	SNF/PED					9
10	ICF	<u>63,035</u>	<u>295</u>		<u>63,330</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,035</u>	<u>295</u>	<u>2,408</u>	<u>65,738</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.17%

D. How many bed-hold days during this year were paid by Public Aid? 367 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☒ NO ☒

I. On what date did you start providing long term care at this location? Date started 11/1/90

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/1/90 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 12 and days of care provided 2,175

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS												
Facility Name & ID Number		COUNTRYSIDE HEALTHCARE CENTER				#	0036632	Report Period Beginning:		01/01/2004	Ending: 12/31/2004	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)												
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	174,570	18,712	16,604	209,886		209,886	(266)	209,620			1
2	Food Purchase		243,442		243,442		243,442	(323)	243,119			2
3	Housekeeping	142,023	29,586		171,609		171,609		171,609			3
4	Laundry	63,637	15,268		78,905		78,905		78,905			4
5	Heat and Other Utilities			116,673	116,673		116,673	911	117,584			5
6	Maintenance	50,897	37,858	17,127	105,882		105,882	9,278	115,160			6
7	Other (specify):*			10,939	10,939		10,939	478	11,417			7
8	TOTAL General Services	431,127	344,866	161,343	937,336		937,336	10,078	947,414			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	1,467,084	67,123	236,892	1,771,099		1,771,099	(194,981)	1,576,118			10
10a	Therapy	65,849	2,964	39,978	108,791		108,791	(29,544)	79,247			10a
11	Activities	96,251	20,433		116,684		116,684		116,684			11
12	Social Services	320,595			320,595		320,595		320,595			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,949,779	90,520	280,870	2,321,169		2,321,169	(224,525)	2,096,644			16
	C. General Administration											
17	Administrative	124,671		444,000	568,671		568,671	(350,116)	218,555			17
18	Directors Fees											18
19	Professional Services			316,922	316,922		316,922	(250,212)	66,710			19
20	Dues, Fees, Subscriptions & Promotions			31,990	31,990		31,990	(10,238)	21,752			20
21	Clerical & General Office Expenses	163,278	16,890	170,532	350,700		350,700	(67,543)	283,157			21
22	Employee Benefits & Payroll Taxes			373,985	373,985		373,985		373,985			22
23	Inservice Training & Education			2,963	2,963		2,963	1,684	4,647			23
24	Travel and Seminar							554	554			24
25	Other Admin. Staff Transportation			746	746		746	5,595	6,341			25
26	Insurance-Prop.Liab.Malpractice			253,768	253,768		253,768	3,520	257,288			26
27	Other (specify):*							62,063	62,063			27
28	TOTAL General Administration	287,949	16,890	1,594,906	1,899,745		1,899,745	(604,693)	1,295,052			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,668,855	452,276	2,037,119	5,158,250		5,158,250	(819,140)	4,339,110			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	11,606
	REPAIRS & MAINTENANCE		4,998
			0
			16,604
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		28,893
	ELECTRICITY		64,153
	WATER		23,054
	CABLE TV - LOBBY		573
			0
			116,673
6	MAINTENANCE		
	GROUND'S MAINTENANCE		2,383
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		7,236
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		4,156
	FIRE SERVICE		3,352
			0
			0
			0
			17,127
7	OTHER		
	SCAVENGER		10,939
	SECURITY SERVICE		0
			10,939
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,000
			4,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112
	PHARMACY CONSULTANT	XVIII B 39-2	1,180
	UTILIZATION REVIEW FEES	XVIII B __-2	25,000
	PHYSICIANS	XVIII B __-2	55,000
	PSYCHIATRIC	XVIII B __-2	150,000
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL SERVICES		3,600
			0
			236,892
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		2,309
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		4,154
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	THERAPY CONTRACT SERVICES	XVIII B 43-2	19,115
			39,978
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 444,000	444,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 28,433	
	ADMINISTRATIVE CONSULTANTS	XIX C 241,000	
	PROFESSIONAL FEES	XIX C 47,489	
		0	316,922
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 12,490	
	EMPLOYEE WANT ADS	XIX F 13,935	
	CONTRIBUTIONS	VI 20 XIX F 50	
	DUES & SUBSCRIPTIONS	XIX F 0	
	LICENSES & PERMITS	XIX F 3,707	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 1,658	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	31,990
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,120	
	EQUIPMENT REPAIR & MAINTENANCE	6,231	
	OUTSIDE CLERICAL SERVICES	120,292	
	PENALTIES / OVERDRAFT CHARGES	VI 18 23,115	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	500	
	TELEPHONE	17,053	
	MESSENGER SERVICE	2,221	
		0	170,532

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 201,434	
	UNEMPLOYMENT COMPENSATION	XIX D 68,357	
	WORKERS COMPENSATION INSURANCE	XIX D 46,080	
	HOSPITALIZATION INSURANCE	XIX D 51,616	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,080	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 1,418	
	CHICAGO HEAD TAX	XIX D 0	373,985
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,963	2,963
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	746	746
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	253,768	253,768
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

2,037,119

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,203	44,203		44,203	190,616	234,819			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,308	47,308		47,308	493,118	540,426			32
33	Real Estate Taxes			454,161	454,161		454,161		454,161			33
34	Rent-Facility & Grounds			915,797	915,797		915,797	(907,511)	8,286			34
35	Rent-Equipment & Vehicles			47,222	47,222		47,222	(16,874)	30,348			35
36	Other (specify):*											36
37	TOTAL Ownership			1,508,691	1,508,691		1,508,691	(240,651)	1,268,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,733	37,800	111,533		111,533	(31,616)	79,917			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,154	108,154		108,154		108,154			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		73,733	145,954	219,687		219,687	(31,616)	188,071			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,668,855	526,009	3,691,764	6,886,628		6,886,628	(1,091,407)	5,795,221			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,874)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(323)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(23,115)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(12,490)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,658)	20		28
29	Other-Attach Schedule SEE PAGE 5 A	(66,985)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,645)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(980,762)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (980,762)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,091,407)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0036632

Report Period Beginning:01/01/2004

Ending:12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING	\$ -66985	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(66,985)		49

Summary A

12/31/2004

[illegible]

Summary B

Facility Name & ID Number

0036632

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE						
				COUNTRYSIDE		
				H/C LLC	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 915,797	COUNTRYSIDE HEALTHCARE CENTER, LLC		\$	(915,797)	1
2	V	30	SL DEPRECIATION				182,982	182,982	2
3	V	32	INTEREST				454,365	454,365	3
4	V								4
5	V								5
6	V								6
7	V	10A	THERAPY SERVICES	39,977	CAREPLUS REHABILITATIVE SERVICES		5,807	(34,170)	7
8	V	39	ANCILLARY THERAPY	37,800			6,184	(31,616)	8
9	V	35	EQUIPMENT RENT	25,864				(25,864)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,019,438			\$ 649,338	\$ * (370,100)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONSULT FEES	\$ 4,200	CAREPLUS MGMT. INC.		\$	\$ (4,200)	15
16	V	17	MANAGEMENT FEES	444,000				(444,000)	16
17	V	19	ADMIN. CONSULT FEES	241,000				(241,000)	17
18	V	19	DATA PROCESS FEES	14,400				(14,400)	18
19	V	21	CLERICAL FEES	118,200				(118,200)	19
20	V	10	MEDICARE CONSULT. FEES	25,000				(25,000)	20
21	V	10	PA CONSULTANT FEES	55,000				(55,000)	21
22	V	10	PSYCHIATRIC CONS. FEE	150,000				(150,000)	22
23	V								23
24	V	1	DIETARY SALARIES				3,934	3,934	24
25	V	5	UTILITIES				911	911	25
26	V	6	MAINT & REPAIRS				32	32	26
27	V	6	MAINTENANCE SALARIES				9,246	9,246	27
28	V	10	NURSING SALARIES				35,019	35,019	28
29	V	10A	THERAPY SALARIES				4,626	4,626	29
30	V	17	ADMIN SALARIES				93,884	93,884	30
31	V	19	PROFESSIONAL FEES				5,188	5,188	31
32	V	20	ADVERTISING				4,110	4,110	32
33	V	21	TOTAL OFFICE				45,531	45,531	33
34	V	21	CLERICAL SALARIES				95,226	95,226	34
35	V	23	SEMINAR				1,684	1,684	35
36	V	24	TRAVEL				554	554	36
37	V	25	TRANSPORTATION				5,595	5,595	37
38	V	26	INSURANCE				3,520	3,520	38
39	Total			\$ 1,051,800			\$ 309,060	\$ * (742,740)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	EMPLOYEE BENEFITS	\$	CAREPLUS MGMT. INC.		\$ 62,063	\$ 62,063	15
16	V	30	DEPRECIATION (SL)				13,508	13,508	16
17	V	32	INTEREST				38,753	38,753	17
18	V	34	OFFICE RENT				8,286	8,286	18
19	V	35	EQUIPMENT RENT				8,990	8,990	19
20	V	7	SECURITY				478	478	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 132,078	\$ * 132,078	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGT ALLOCATIONS:								\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	36.17	SEE ATTACHED	7		SALARY	21,503	17-7	2
3			FINANCE		SCHEDULE						3
4	JACOB BAKST	DIR OPERATIONS	ADMINISTRAT.	21.57		7		SALARY	21,503	17-7	4
5			CONSULTING								5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		7		SALARY	6,777	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,783		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPLUS MANAGEMENT, INC.
Street Address 8320 SKOKIE BLVD.
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 329-1555
Fax Number (847) 329-9555

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,049	9	\$ 26,990	\$	65,738	\$ 3,934	1
2	5	UTILITIES	CENSUS DAYS	565,586	13	7,834		65,738	911	2
3	6	MAINT & REPAIRS	CENSUS DAYS	565,586	13	275		65,738	32	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	565,586	13	79,548		65,738	9,246	4
5	10	NURSING SALARIES	CENSUS DAYS	565,586	13	301,295		65,738	35,019	5
6	10A	THERAPY SALARIES	CENSUS DAYS	565,586	13	39,798		65,738	4,626	6
7	17	ADMIN SALARIES	CENSUS DAYS	565,586	13	807,745		65,738	93,884	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	565,586	13	44,637		65,738	5,188	8
9	20	ADVERTISING	CENSUS DAYS	565,586	13	35,362		65,738	4,110	9
10	21	TOTAL OFFICE	CENSUS DAYS	565,586	13	391,736		65,738	45,531	10
11	21	CLERICAL SALARIES	CENSUS DAYS	565,586	13	819,289		65,738	95,226	11
12	23	SEMINAR	CENSUS DAYS	565,586	13	14,490		65,738	1,684	12
13	24	TRAVEL	CENSUS DAYS	565,586	13	4,769		65,738	554	13
14	25	TRANSPORTATION	CENSUS DAYS	565,586	13	48,136		65,738	5,595	14
15	26	INSURANCE	CENSUS DAYS	565,586	13	30,286		65,738	3,520	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	565,586	13	533,964		65,738	62,063	16
17	30	DEPRECIATION (SL)	CENSUS DAYS	565,586	13	116,219		65,738	13,508	17
18	32	INTEREST	CENSUS DAYS	565,586	13	333,416		65,738	38,753	18
19	34	OFFICE RENT	CENSUS DAYS	565,586	13	71,288		65,738	8,286	19
20	35	EQUIPMENT RENT	CENSUS DAYS	565,586	13	77,344		65,738	8,990	20
21	7	SECURITY	CENSUS DAYS	565,586	13	4,112		65,738	478	21
22										22
23										23
24										24
25	TOTALS					\$ 3,788,533	\$		\$ 441,138	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY: COUNTRYSIDE HEALTHCARE CENTER, LLC						\$					\$	1		
2	CORUS BANK		X	MORTGAGE	\$50,182.00	05/98		4,343,980	2,562,827	06/05	0.0939	266,007	2		
3	COUNTRYSIDE PLAZA		X	JR MORTGAGE	\$17,307.38	05/98		1,978,877	1,803,506	05/08	0.0950	173,137	3		
4	CIB BANK		X	CAPITAL IMPROVEMENTS	\$6,078.93	01/04		540,000	203,057	01/09	PRIME+	14,051	4		
5	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS			2,700		W/O BAL		1,170	5		
	Working Capital														
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95		1,015,000			PRIME+	42,826	6		
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING								4,482	7		
8	MGMT CO ALLOCATION											38,753	8		
9	TOTAL Facility Related				\$73,568.31		\$	7,880,557	\$	4,569,390			\$	540,426	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	7,880,557	\$	4,569,390			\$	540,426	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.			\$	438,460	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	444,090	2
3. Under or (over) accrual (line 2 minus line 1).			\$	5,630	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	448,531	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	454,161	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	431,573	8	
		2000	408,867	9	
		2001	458,382	10	
		2002	434,119	11	
		2003	444,090	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

COUNTRYSIDE HEALTHCARE CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0036632

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	29-13-100-001-0000	NURSING HOME	\$ 444,089.74	\$ 444,089.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 444,089.74	\$ 444,089.74

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,547

B. General Construction Type: Exterior BRICKFrame STEELNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	132,928	1998	\$ 392,750	1
2					2
3	TOTALS	132,928		\$ 392,750	3

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	1997		1998		\$ 5,408,525	\$ 138,675	39	\$ 138,675	\$	\$ 918,857	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	24,648	782	31.5	782		10,835	9
10	LEASEHOLD IMPROVEMENTS			1992	28,172	894	31.5	894		11,221	10
11	LEASEHOLD IMPROVEMENTS			1993	11,940	337	31.5	337		4,232	11
12	LEASEHOLD IMPROVEMENTS			1994	4,878	125	39	125		1,294	12
13	TILE / ROOF VENTS			1995	16,191	416	39	416		3,957	13
14	WALL / WATER PANEL			1995	4,199	107	39	107		1,001	14
15	LANDSCAPING/PARKING LOT REPAIRS			1995	13,614	908	15	908		8,625	15
16	ROOF REPAIRS			1996	13,369	342	39	342		2,957	16
17	SINK			1996	683	18	39	18		153	17
18	ROOF-TOP A/C UNIT			1996	5,100	131	39	131		1,075	18
19	WINDOWS			1996	1,080	28	39	28		227	19
20	WINDOWS			1997	14,040	360	39	360		2,713	20
21	WALK-IN FREEZER			1997	3,196	82	39	82		605	21
22	WINDOWS			1998	8,370	214	39	214		1,432	22
23	FLOORING / TILE / CARPETING			1998	3,396	87	39	87		579	23
24	CEILING TILES			1998	2,213	57	39	57		354	24
25	ROOF REPAIRS / ROOFTOP A/C			1999	33,838	868	39	868		4,665	25
26	ROOF REPAIRS			2000	13,505	346	39	346		1,687	26
27	INSTALLATION CORNICES & SHEERS			2000	3,280	119	27.5	119		541	27
28	DRAPERY PANELS			2000	2,170	218	20	109	(109)	545	28
29	CARPETING OFFICES			2001	1,814	209	20	91	(118)	364	29
30	INSTALLED ROOF TOP UNIT			2001	6,992	254	27.5	254		773	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING,CEILING			2003	100,619	3,659	27.5	3,659		6,251	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS			2003	4,501	1,440	20	225	(1,215)	450	32
33	REPLACE FIRE ALARM SYSTEM			2003	5,204	189	27.5	189		244	33
34	NEW DURO-LAST ROOFING SYSTEM			2003	28,200	1,022	27.5	1,022		1,065	34
35	PAINTING			2004	4,100	820	20	205	(615)	205	35
36	BATHROOMS AND OFFICE REMODELING			2004	43,350	66	27.5	66		66	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPLACED FRONT DOOR	2004	\$ 2,164	\$ 56	27.5	\$ 56	\$	\$ 56	37
38									38
39									39
40									40
41									41
42	COUNTRYSIDE HEALTHCARE CENTER LLC:ROOF	2001		9,123	39	9,123		30,031	42
43									43
44									44
45	CAREPLUS MANAGEMENT INC: LEASEHOLD IMPROVEMENT			137		137			45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,813,351	\$ 162,089		\$ 160,032	\$ (2,057)	\$ 1,017,060	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 284,596	\$ 17,805	\$ 25,050	\$ 7,245	3-15	\$ 165,885	71
72	Current Year Purchases	20,405	12,244	1,182	(11,062)	8-10	1,182	72
73	Fully Depreciated Assets	30,609					30,609	73
74	RELATED PARTY ALLOC: SL DEPR		48,555	48,555				74
75	TOTALS	\$ 335,610	\$ 78,604	\$ 74,787	\$ (3,817)		\$ 197,676	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	6,541,711
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	240,693
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	234,819
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(5,874)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,214,736

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 39,032 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 DODGE RAM	\$ 682.00	\$ 8,190	17
18					18
19					19
20					20
21	TOTAL		\$ 682.00	\$ 8,190	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS

(d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 22,545	\$		\$ 22,545	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			15,255			15,255	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				70,955		70,955	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): RENTALS	39-2 39-2					2,730 48		2,730 48	13
14	TOTAL			\$		\$ 37,800	\$ 73,733		\$ 111,533	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (85,238)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,849,326		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,045		6
7	Other Prepaid Expenses	24,178		7
8	Accounts Receivable (owners or related parties)	112,479		8
9	Other(specify): Real Estate Tax Escrow	104,342		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,124,132	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	404,726		15
16	Equipment, at Historical Cost	335,610		16
17	Accumulated Depreciation (book methods)	(375,586)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 364,750	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,488,882	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 538,803	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	64,734		28
29	Short-Term Notes Payable	1,000,587		29
30	Accrued Salaries Payable	89,122		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,535		31
32	Accrued Real Estate Taxes(Sch.IX-B)	448,531		32
33	Accrued Interest Payable	2,555		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,164,867	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,164,867	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,324,015	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,488,882	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,156,584	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(890,884)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,265,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	58,315	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,315	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,324,015	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,944,943	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,944,943	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,944,943	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	937,336	31
32	Health Care	2,321,169	32
33	General Administration	1,899,745	33
	B. Capital Expense		
34	Ownership	1,508,691	34
	C. Ancillary Expense		
35	Special Cost Centers	111,533	35
36	Provider Participation Fee	108,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,886,628	40
41	Income before Income Taxes (line 30 minus line 40)**	58,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 58,315	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,925	2,061	\$ 71,637	\$ 34.76	1
2	Assistant Director of Nursing	1,935	2,230	64,801	29.06	2
3	Registered Nurses	4,431	4,461	101,639	22.78	3
4	Licensed Practical Nurses	30,048	32,440	633,715	19.53	4
5	Nurse Aides & Orderlies	58,726	63,331	572,984	9.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,275	6,919	65,849	9.52	8
9	Activity Director	1,957	2,122	33,784	15.92	9
10	Activity Assistants	7,317	8,212	62,467	7.61	10
11	Social Service Workers	19,076	20,295	320,595	15.80	11
12	Dietician					12
13	Food Service Supervisor	2,043	2,129	33,665	15.81	13
14	Head Cook	4,994	5,585	49,737	8.91	14
15	Cook Helpers/Assistants	12,951	13,540	91,168	6.73	15
16	Dishwashers					16
17	Maintenance Workers	3,858	4,281	50,897	11.89	17
18	Housekeepers	17,794	18,960	142,023	7.49	18
19	Laundry	8,684	9,203	63,637	6.91	19
20	Administrator	1,910	2,117	77,954	36.82	20
21	Assistant Administrator	2,089	2,419	46,717	19.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,789	6,166	96,293	15.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,246	2,416	22,308	9.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	1,966	2,132	66,985	31.42	33
34	TOTAL (lines 1 - 33)	195,014	211,019	\$ 2,668,855 *	\$ 12.65	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 11,606	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	2,112	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,180	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	S	55,000	10-3	46
47	<u>UTILIZATION REVIEW FEES</u>		25,000	10-3	47
48	<u>PSYCHIATRIC</u>		150,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 263,298		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
MARIANNE SPRATT	ADMIN	0	\$ 77,954	Workers' Compensation Insurance		\$ 46,080	IDPH License Fee	\$ 2,970
MONIQUE MOORE	ASST ADMIN	0	40,544	Unemployment Compensation Insurance		68,357	Advertising: Employee Recruitment	13,935
KIERRONIS MCDOWELL	ASST ADMIN	0	6,173	FICA Taxes		201,434	Health Care Worker Background Check	0
				Employee Health Insurance		51,616	(Indicate # of checks performed _____)	
				Employee Meals		#REF!	MARKETING/ADV/PROMO	14,148
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	200
				EMPLOYEE BENEFITS - OTHER		5,080	LICENSES & PERMITS	737
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	0
				PENSION/PROFIT SHARING PLANS		1,418	MGMT CO ALLOCATION	4,110
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 124,671	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(200)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(12,490)
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			Yellow page advertising	(1,658)
CAREPLUS MGMT MANAGEMENT FEES			\$ 444,000	\$ #REF!			TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 21,752	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 444,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							MGMT CO ALLOCATION	554
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			316,922				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 316,922	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)				\$			\$ 554	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 455 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 108,154
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees